

North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch

**ATTENTION HEALTH CARE PROVIDERS:**

Please report relevant clinical findings about this disease event to the local health department.

CAMPYLOBACTER INFECTION
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 50

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /	SSN
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**NC EDSS
LAB RESULTS**

Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	



**NC EDSS PART 2 WIZARD
COMMUNICABLE DISEASE**

Is/was patient symptomatic for this disease? ☐ Y ☐ N ☐ U

If yes, symptom onset date (mm/dd/yyyy): ____/____/____

CHECK ALL THAT APPLY:

Fever ☐ Y ☐ N ☐ U

☐ Yes, subjective ☐ No
☐ Yes, measured ☐ Unknown

Highest measured temperature _____

Fever onset date (mm/dd/yyyy): ____/____/____

Fatigue or malaise or weakness ☐ Y ☐ N ☐ U

Guillain-Barre Syndrome ☐ Y ☐ N ☐ U

Arthritis ☐ Y ☐ N ☐ U

Extent: ☐ One joint ☐ Multiple joints
☐ Reactive

Nausea ☐ Y ☐ N ☐ U

Vomiting ☐ Y ☐ N ☐ U

Abdominal pain or cramps ☐ Y ☐ N ☐ U

Diarrhea ☐ Y ☐ N ☐ U

Describe (select all that apply)

☐ Bloody ☐ Non-bloody
☐ Watery ☐ Other

Maximum number of stools in a 24-hour period: _____

Other symptoms, signs, clinical findings, or complications consistent with this illness ☐ Y ☐ N ☐ U

Please specify: _____

During the 10 days prior to onset of symptoms, did the patient have exposure to animals

(includes animal tissues, animal products, or animal excreta)? ☐ Y ☐ N ☐ U

Household pets? ☐ Y ☐ N ☐ U

Specify pet(s): _____

Did patient own, work at, or visit a pet store, animal shelter, and/or animal breeder/wholesaler/distributor? ☐ Y ☐ N ☐ U

Did the patient handle any animals? ☐ Y ☐ N ☐ U

Species: _____

Did patient/household contact work at, live on, or visit a farm, ranch, or dairy? ☐ Y ☐ N ☐ U

Was patient exposed to animals associated with agriculture or aviculture (domestic/semi-domestic animals)? ☐ Y ☐ N ☐ U

PREDISPOSING CONDITIONS

Any immunosuppressive conditions? ☐ Y ☐ N ☐ U

Specify: _____

REASON FOR TESTING

Why was the patient tested for this condition?

- ☐ Symptomatic of disease
☐ Screening of asymptomatic person with reported risk factor(s)
☐ Exposed to organism causing this disease (asymptomatic)
☐ Household/close contact to a person reported with this disease
☐ Other, specify _____
☐ Unknown

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours? ☐ Y ☐ N ☐ U

Hospital name: _____

City, State: _____

Hospital contact name: _____

Telephone: (____) _____ - _____

Admit date (mm/dd/yyyy): ____/____/____

Discharge date (mm/dd/yyyy): ____/____/____

CLINICAL OUTCOMES

Discharge/Final diagnosis: _____

Survived? ☐ Y ☐ N ☐ U

Died? ☐ Y ☐ N ☐ U

Died from this illness? ☐ Y ☐ N ☐ U

Date of death (mm/dd/yyyy): ____/____/____

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN / /

TRAVEL/IMMIGRATION

The patient is:
☐ Resident of NC
☐ Resident of another state or US territory
☐ None of the above

Did patient have a travel history during the 10 days prior to onset of symptoms? ☐ Y ☐ N ☐ U

List travel dates and destinations:
 From ____/____/____ to ____/____/____

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? ☐ Y ☐ N ☐ U

List persons and contact information:

Additional travel/residency information:

ISOLATION/QUARANTINE/CONTROL MEASURES

Restrictions to movement or freedom of action? ☐ Y ☐ N

Check all that apply:
☐ Work ☐ Sexual behavior
☐ Child care ☐ Blood and body fluid
☐ School ☐ Other, specify _____

Date control measures issued: _____
 Date control measures ended: _____
 Was patient compliant with control measures? ☐ Y ☐ N

Did local health director or designee implement additional control measures? ☐ Y ☐ N

If yes, specify: _____

Were written isolation orders issued? ☐ Y ☐ N

If yes, where was the patient isolated? _____

Date isolation started? _____
 Date isolation ended? _____
 Was the patient compliant with isolation? ☐ Y ☐ N

CHILD CARE/SCHOOL/COLLEGE

Patient in child care? ☐ Y ☐ N ☐ U

Patient a child care worker or volunteer in child care? ☐ Y ☐ N ☐ U

Patient a parent or primary caregiver of a child in child care? ☐ Y ☐ N ☐ U

Is patient a student? ☐ Y ☐ N ☐ U

Type of school: _____

Is patient a school WORKER / VOLUNTEER in NC school setting? ☐ Y ☐ N ☐ U

Give details: _____

BEHAVIORAL RISK & CONGREGATE LIVING

During the 10 days prior to onset of symptoms, did the patient live in any congregate living facilities (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)? ☐ Y ☐ N ☐ U

Name of facility: _____

Dates of contact: from ____/____/____ until ____/____/____

During the 10 days prior to onset of symptoms, did the patient attend social gatherings or crowded settings? ☐ Y ☐ N ☐ U

If yes, specify: _____

In what setting was the patient most likely exposed?

<input type="checkbox"/> Restaurant	<input type="checkbox"/> Place of Worship
<input type="checkbox"/> Home	<input type="checkbox"/> Outdoors, including woods or wilderness
<input type="checkbox"/> Work	<input type="checkbox"/> Athletics
<input type="checkbox"/> Child Care	<input type="checkbox"/> Farm
<input type="checkbox"/> School	<input type="checkbox"/> Pool or spa
<input type="checkbox"/> University/College	<input type="checkbox"/> Pond, lake, river or other body of water
<input type="checkbox"/> Camp	<input type="checkbox"/> Hotel / motel
<input type="checkbox"/> Doctor's office/ Outpatient clinic	<input type="checkbox"/> Social gathering, other than listed above
<input type="checkbox"/> Hospital In-patient	<input type="checkbox"/> Travel conveyance (airplane, ship, etc.)
<input type="checkbox"/> Hospital Emergency Department	<input type="checkbox"/> International
<input type="checkbox"/> Laboratory	<input type="checkbox"/> Community
<input type="checkbox"/> Long-term care facility / Rest Home	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Military	<input type="checkbox"/> Unknown
<input type="checkbox"/> Prison/Jail/Detention Center	

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? ☐ Y ☐ N ☐ U

If yes, specify: _____

ANIMAL EXPOSURE

In the 10 days prior to onset of symptoms, did the patient:

Have contact with commercial animal products (i.e. wool, hair, hides, fur, raw/smoked meat, bones, bone meal)? ☐ Y ☐ N ☐ U

Work at or visit a slaughterhouse (abattoir), meat-packing plant, poultry or wild game processing facility? ☐ Y ☐ N ☐ U

Work at or visit a fair with livestock or a petting zoo? ☐ Y ☐ N ☐ U

Work at or visit a zoo, zoological park, or aquarium? ☐ Y ☐ N ☐ U

Work in a veterinary practice or animal laboratory, animal research setting, biomedical laboratory, or an animal diagnostic laboratory? ☐ Y ☐ N ☐ U

Provide the nature of contact, dates, location, and other specifics for any question answered yes.

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specify location:
☐ In NC
 City _____
 County _____
☐ Outside NC, but within US
 City _____
 State _____
 County _____
☐ Outside US
 City _____
 Country _____
☐ Unknown

Is the patient part of an outbreak of this disease? ☐ Y ☐ N

Notes:

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? ☐ Y ☐ N ☐ U

Date of interview (mm/dd/yyyy): ____/____/____

Were interviews conducted with others? ☐ Y ☐ N ☐ U

Who was interviewed? _____

Were health care providers consulted? ☐ Y ☐ N ☐ U

Who was consulted? _____

Medical records reviewed (including telephone review with provider/office staff)? ☐ Y ☐ N ☐ U

Specify reason if medical records were not reviewed: _____

Notes on medical record verification:

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN / /

FOOD RISK AND EXPOSURE

During the 10 days prior to onset of symptoms, did the patient eat any raw or undercooked meat or poultry? ☐ Y ☐ N ☐ U

Specify meat/poultry: _____
Specify place of exposure: _____

Where does the patient/patient's family typically buy groceries?

Store name: _____
Store city: _____
Shopping center name/address: _____

Did the patient drink any bottled water? ☐ Y ☐ N ☐ U

Specify type/brand: _____
Describe the source of drinking water used in the patient's home. Check all that apply:

- ☐ Bottled water supplied by a company
☐ Bottled water purchased from a grocery store
☐ Municipal supply (city water)
☐ Well water

During the 10 days prior to onset of symptoms, did the patient:

Eat any food items that came from a produce stand, flea market, or farmer's market? ☐ Y ☐ N ☐ U

Specify source: _____
Eat any food items that came from a store or vendor where they do not typically shop for groceries? ☐ Y ☐ N ☐ U

Specify source(s): _____
During the 10 days prior to onset of symptoms, was the patient:

Employed as food worker? ☐ Y ☐ N ☐ U
Where employed? _____
Specify job duties: _____
What dates did the patient work?
From ____/____/____ until ____/____/____

Employed as food worker while symptomatic? ☐ Y ☐ N ☐ U
Where did the patient work? _____
What dates did the patient work?
From ____/____/____ until ____/____/____
What day did the patient return to food service work?
Date: ____/____/____
Where did patient return to work? _____

Non-occupational food worker? (e.g. potlucks, receptions) during contagious period ☐ Y ☐ N ☐ U
Where employed? _____
Specify dates worked during contagious period:
From ____/____/____ until ____/____/____

Health care worker or child care worker handling food or medication in the contagious period? ☐ Y ☐ N ☐ U
Where employed? _____
Specify dates worked during contagious period: _____

During the 10 days prior to onset of symptoms, did the patient:

Handle raw meat other than poultry? ☐ Y ☐ N ☐ U
Specify type of meat:
☐ Beef (hamburger/steak, etc)
☐ Pork (ham, bacon, pork chops, sausage, etc)
☐ Lamb/mutton
☐ Wild game, specify: _____
☐ Other, specify: _____
☐ Unknown

Handle raw poultry? ☐ Y ☐ N ☐ U

Specify type of poultry:
☐ Chicken
☐ Turkey
☐ Other, specify: _____
☐ Unknown

Drink unpasteurized milk? ☐ Y ☐ N ☐ U

Specify type of milk:
☐ Cow
☐ Goat
☐ Sheep
☐ Other, specify: _____
☐ Unknown

Eat any other unpasteurized dairy products? ☐ Y ☐ N ☐ U

Specify type of product:
☐ Queso fresco, Queso blanco or other Mexican soft cheese
☐ Butter
☐ Cheese from raw milk, specify: _____
☐ Food made from raw dairy product, specify: _____
☐ Other, specify: _____

Eat ground beef/hamburger? ☐ Y ☐ N ☐ U

Eat other beef/beef products? ☐ Y ☐ N ☐ U

☐ Roast
☐ Steak
☐ Other (specify): _____
☐ Unknown

Eat any poultry/poultry product? ☐ Y ☐ N ☐ U

☐ Chicken
☐ Turkey
☐ Other (specify): _____
☐ Unknown

Eat pork/pork products? ☐ Y ☐ N ☐ U

Specify type of pork/pork product:
☐ Sausage
☐ Smoked ☐ Unsmoked
☐ Chops
☐ Roast
☐ Ham
☐ Smoked ☐ Cured ☐ Canned
☐ Other, specify: _____
☐ Bacon
☐ BBQ
☐ Other, specify: _____

Eat wild game meat (bear, buffalo, deer, wild boar)? ☐ Y ☐ N ☐ U

Specify type of wild game meat:
☐ Deer/venison
☐ Bear
☐ Wild boar/javelina/feral hog
☐ Other, specify: _____

Eat other meat / meat products (i.e. ostrich, emu, horse)? ☐ Y ☐ N ☐ U

Specify other meat/meat product:
☐ Ostrich
☐ Emu
☐ Horse
☐ Other, specify: _____

Eat prepackaged, processed meat/meat products (does not include dried, smoked, or preserved products)? ☐ Y ☐ N ☐ U

Specify type of prepackaged, processed meat/meat product:

- ☐ Hot dogs
☐ Cold Cuts
☐ Bologna
☐ Turkey
☐ Ham
☐ Other cold cut, specify: _____

Any other ready-to-eat meat? Specify: _____

Eat ready-to-eat dried, preserved, smoked, or traditionally prepared meat (i.e. summer sausage, salami, jerky)? ☐ Y ☐ N ☐ U

Specify type of prepared meat:
☐ Summer sausage, specify: _____
☐ Salami
☐ Jerky
☐ Other, specify: _____

Eat deli-sliced (not pre-packaged) meat? ☐ Y ☐ N ☐ U

Specify type of meat:
☐ Bologna
☐ Turkey
☐ Ham
☐ Roast beef
☐ Chicken
☐ Other, specify: _____

Eat meat stews or meat pies? ☐ Y ☐ N ☐ U

Specify: _____

Eat gravy (i.e. beef, chicken, turkey)? ☐ Y ☐ N ☐ U

Specify: _____

Eat at a group meal? ☐ Y ☐ N ☐ U

Specify:
☐ Place of Worship
☐ School
☐ Social function
☐ Other, Specify: _____

Eat food from a restaurant? ☐ Y ☐ N ☐ U

Name: _____
Location: _____

Did the patient ingest breast milk? ☐ Y ☐ N ☐ U

Source of milk: _____

Did the patient ingest infant formula? ☐ Y ☐ N ☐ U

Type: _____

Did the patient eat commercial baby food? ☐ Y ☐ N ☐ U

Type: _____

Notes:

Campylobacter infection (*Campylobacter* spp.)

1990 CDC Case Definition

Clinical description

An infection that may result in diarrheal illness of variable severity

Laboratory criteria for diagnosis

- Isolation of *Campylobacter* from any clinical specimen

Case classification

Probable: a clinically compatible case that is epidemiologically linked to a confirmed case

Confirmed: a case that is laboratory confirmed

Comment

Only confirmed cases are reported to the laboratory-based surveillance system managed by the Foodborne and Diarrheal Diseases Branch, Division of Bacterial and Mycotic Diseases, National Center for Infectious Diseases, CDC.